

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

63-028097

STATE FILE NUMBER

DO NOT WRITE
ON THIS SUB

AMENDED

Registration District No. 422 Primary Registration District No. 4231 Registrar's No. 35

VS 300
Rev. 4/59

1 0460

2 1010

3 1

4 1

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7 0

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9 331X

10

11

12 2-0

13 1/2

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

SHOULD READ

ITEM NO.

DOCUMENT

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY <u>Howell</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo</u> b. COUNTY <u>Shannon</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Mtn. View</u>		c. CITY OR TOWN <u>Montier</u> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>St. Francis Hosp</u>		d. STREET ADDRESS (If outside, give location) <u>XXX</u> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Maude</u> Middle <u>Ellen</u> Last <u>Smith</u>		4. DATE OF DEATH Month <u>July</u> Day <u>14</u> Year <u>1963</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>6/7/78</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Bakersfield, Mo</u>	
11. BIRTHPLACE (City and state or country) <u>USA</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13a. FATHER'S NAME <u>Tom Kirkland</u>		13b. MOTHER'S MAIDEN NAME <u>Mary Ellen Jones</u>	
14. NAME OF HUSBAND OR WIFE <u>John Smith</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>	
16. SOCIAL SECURITY NO. <u>Arroll, Mo.</u>		17. INFORMANT <u>Rt. 1</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral vascular accident</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>generalized arteriosclerosis</u> DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour _____ a.m. _____ p.m. Month, Day, Year _____	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION COUNTY STATE	
21. I attended the deceased from <u>July 1, 1963</u> to <u>July 14, 1963</u> and last saw her/him alive on <u>July 14, 1963</u> . Death occurred at <u>July 14, 1963</u> on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>M.C. Walton M.D.</u>		22b. ADDRESS <u>Mountain View, Mo.</u>	
22c. DATE SIGNED		23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	
23b. DATE <u>7/16/63</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Montier Cem.</u>	
23d. LOCATION (City, town, or county) (State) <u>Montier, Missouri</u>		24. FUNERAL DIRECTOR ADDRESS <u>Duncan Funeral Home Mtn. View, Mo.</u>	
25. DATE RECD. BY LOCAL REG. <u>7-30-1963</u>		26. REGISTRAR'S SIGNATURE <u>Charles D. Cartain</u>	

To Doctor 8: A.M. July 15-63

Rec'd from Dr. 12: Noon 7/29/63

To Local Reg. 12:15 P.M. 7/29/63

Burial Permit issued

OCT 15 1963

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,

or by _____, Student Embalmer No. _____

working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed

Charles D. Cartain

Licensed Embalmer No.

5107

P. O. Address

Mt. View, Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.